2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until Medicaid aggregate payments are equal to or less than the amount that would be paid for services under the Medicare reimbursement principles.

3. If provisions 1 and 2 are implemented in order to meet the upper limit test, for a period of 1 year, this plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

N. Payments made under this plan are subject to retroactive adjustment if approval of this plan or any part of this plan is not received from the federal Health Care Financing Administration (HCFA). The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this plan not authorized by HCFA.

V. Method

This section defines the methodologies to be used by the Florida Medicaid program in establishing reimbursement ceilings and individual nursing home reimbursement rates.

A. Ceilings.

1. Ceilings shall be determined prospectively and shall be effective semi-annually on January 1 and July 1. The most current acceptable cost reports postmarked or accepted by a common carrier by September 30 or March 31 and received by October 15 or April 15, respectively, of each year and the provider's most recent reimbursement rates shall be used to establish the operating and patient care ceilings. More current cost reports shall be used to establish rates if production time permits. The first cost report submissions for all newly-constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end for these newly-constructed facilities must be after October 1, 1977. In addition, all facilities with year-ends prior to that of the one hundredth facility in an

array from most current to least current year end shall not be considered in setting the property cost ceiling. The ceiling for property computed here shall be used for all facilities not yet being reimbursed under FRVS. The ceiling computed at July 1, 1985 shall be used beginning with July 1, 1985 rates, and all subsequent rates for facilities until they begin receiving reimbursement under FRVS. For those facilities being reimbursed under FRVS, the cost per bed ceiling per Section V.E.1.g. of this plan shall be used.

2. For the purpose of establishing reimbursement limits for operating and patient care costs, four classes based on geographic location and facility size were developed. These classes are as follows:

   a. Size 1-100 beds - Northern Florida Counties

   b. Size 101-500 beds- Northern Florida Counties

   c. Size 1-100 beds - Southern Florida Counties

   d. Size 101-500 beds- Southern Florida Counties

   For purposes of defining the four reimbursement classes, the "Southern Florida Counties" shall be comprised of:

Broward	Hardee	Monroe
Charlotte	Hendry	Okeechobee
Collier	Highlands	Palm Beach
Dade	Indian River	Polk
Desoto	Lee	St. Lucie
Glades	Martin	Sarasota

   All remaining Florida Counties shall be "Northern Florida Counties."

3. As of July 1, 1994, two additional reimbursement classes shall be defined as follows:

   a. Size 1-100 beds - Central Florida Counties

   b. Size 101-500 beds - Central Florida Counties

The "Central Florida Counties: shall be comprised of :

Brevard	Manatee	Pinellas
Hardee	Orange	Polk
Highlands	Osceola	Seminole
Hillsborough	Pasco	

The "Northern Florida Counties" and "Southern Florida Counties" shall be comprised of the counties enumerated in Section V.A.2. less the "Central Florida Counties" as defined above.

4. Nursing homes participating in the Medicaid program as of July 1, 1994, and located in Hardee, Highlands, or Polk County, shall be "grand-fathered in," and shall be considered as members of the "Southern Florida Counties" class, until such time that the "Central Florida Counties" class reimbursement ceilings for the operating cost and patient care cost components equal or exceed the corresponding July 1, 1994, "Southern Florida Counties" class ceilings. The "grandfathered-in" provision shall be applied separately for the operating cost and patient care cost components in each of the two facility size classes. That is, nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be considered as members of the applicable "Southern Florida Counties" size class in the operating cost component until such time as the "Central Florida Counties" operating cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" operating cost component ceiling for that class. Nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be considered as members of the applicable "Southern Florida Counties" size class in the patient care cost component until such time as the "Central Florida Counties" patient care cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" patient care cost component ceiling.

B. Setting prospective reimbursement per diems and ceilings. In determining the class ceilings, all calculations for Sections V.B. 1. - V. B. 18. shall be made using the four class, and "Northern Florida Counties" and "Southern Florida Counties" definitions of sections V.A. 2. above. All calculations for Sections V.B.19. - V.B.21 shall be made using the six class and "Central Florida Counties" definition of Section V.A.3. above. The Agency shall:

1. Review and adjust each provider's cost report referred to in A.1. to reflect the result of desk or on-site audits, if available.
2. Reduce a provider's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1997)
3. Determine total allowable Medicaid cost.
4. Determine allowable Medicaid property costs, operating costs, patient care costs, and return on equity or use allowance. Patient care costs include those costs directly attributable to nursing services, dietary costs, activity costs, social services costs, and all medically-ordered therapies. All other costs, exclusive of property cost and return on equity or use allowance costs, are considered operating costs. For providers receiving FRVS payments, the return on equity cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a return on equity for property assets as per Section III.J. and K.
5. Calculate per diems for each of these four cost components by dividing the components' costs by the total number of Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per Section V.E. of this plan.
6. Adjust a facility's operating and patient care per diem costs that resulted from Step B.5 for the effects of inflation by multiplying both of these per diem costs by the fraction: Florida Nursing Home Cost Inflation Index at

midpoint of prospective rate period, divided by the Florida Nursing Home Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Nursing Home Cost Inflation Index is displayed in Appendix A. Only providers being paid a prospective rate under section V.B.6. shall be eligible for the Medicaid Adjustment Rate (MAR).

7. Adjust, for those facilities not being paid under FRVS, all four components of the per diem for low occupancy per a. through g. below. For those facilities being paid under FRVS, adjust the operating cost component, the patient care cost component, and the return on equity or use allowance cost component, but do not adjust the property component for low occupancy.

   a. Calculate the percentage of occupancy for each facility.

   b. Calculate the mean and the standard deviation of the distribution of occupancy levels obtained in 7.a.

   c. Calculate the percentage of Medicaid days to total days for each facility ("percent Medicaid").

   d. Calculate the mean and the standard deviation of the distribution of percent Medicaid obtained in 7.c.

   e. Calculate the adjusted per diem components by multiplying each of the per diem components by the fraction: Individual facility occupancy level, divided by the statewide mean occupancy level less one standard deviation of occupancy levels from Step B.7.b.

   f. The adjustment described in e. above shall not apply to:

      1) Facilities with occupancy levels that exceed the statewide mean occupancy level less one standard deviation;

      2. Facilities with only one cost report filed.

3) Facilities with a percentage of Medicaid days that exceeds the statewide mean less one standard deviation of the percentages of Medicaid days.

g. The occupancy adjustment for operating and patient care costs shall not result in a reduction of more than 30 percent of the applicable class ceiling. The property cost and return on equity or use allowance components shall be adjusted proportionately. The proportionate adjustment for the property and return on equity or use allowance per diems shall be made by multiplying each of those two per diems by the fraction:

The sum of the operating cost per diem, adjusted for occupancy, plus the patient care cost per diem, adjusted for occupancy; divided by the sum of the unadjusted operating cost per diem plus the unadjusted patient care cost per diem.

The property cost component shall not be subject to this low occupancy adjustment if a facility is being reimbursed under FRVS.

8. Determine the statewide property cost per diem ceilings for periods April 1, 1983 to July 1, 1985 as per a. through h. below.

a. Calculate the per diem property cost for the array of newly-constructed facilities by dividing the total property cost by the total patient days for each facility.

b. Calculate the statewide average occupancy for all facilities used in setting the patient care and operating ceilings. Calculate the median occupancy for the array of newly-constructed facilities.

c. Calculate two occupancy-adjusted property per diems:

(l) An average occupancy property per diem is calculated.

The average occupancy property per diem equals the newly-constructed facility occupancy divided by the statewide average occupancy, times the newly-constructed facility property per diem.

(2) A median occupancy property per diem for newly-constructed facilities is calculated as follows:

The median occupancy property per diem equals the newly-constructed facility occupancy, divided by the median of newly-constructed facility occupancies, times the newly-constructed facility property per diem.

d. Adjust the two occupancy-adjusted property per diems for the effects of construction cost inflation by multiplying each by the fraction: Florida Construction Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Construction Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Construction Cost Inflation Index is displayed in Appendix B.

e. Calculate the median and standard deviation of the distributions of average occupancy and median occupancy property per diems.

f. The statewide property cost per diem ceiling for facilities that have more than 18 months operating experience shall be the median of the average occupancy property per diems plus one standard deviation.

g. The statewide property per diem ceiling for facilities that have 18 or fewer months of operating experience shall be the median of the distribution of median occupancy property per diems plus one standard deviation. A facility which has more than 18 months

operating experience shall be subject to a weighted average property ceiling at the addition of beds at 50 percent or more of the existing bed capacity, or the addition of 60 beds or more. A weighted average rate shall be computed, equal to the sum of:

1) Actual per diem costs of the original facility, limited by the lower property ceiling, multiplied by the ratio of its beds to total facility beds; and

2) Actual per diem costs of the addition, limited by the higher property ceiling, multiplied by the ratio of its beds to total facility beds.

This weighted average rate shall be effective for 18 months from the date the additional beds were put into service.

h. Facilities that are not reimbursed based on FRVS shall be subject to the property cost ceilings calculated at July 1, 1985. New property cost ceilings shall not be calculated at subsequent rate semesters.

9. Determine the median inflated operating and patient care costs per diems for each of the four-classes and for the whole State.

10. For each of the per diems in 9. above, calculate the ratios for each of the four-class medians to the State medians.

11. Divide individual facility operating cost per diems and patient care cost per diems that resulted from Step B.7. by the ratio calculated for the facility's class in Step 10.

12. Determine the statewide median for the per diems obtained in Step B.11.

13. For each of the operating and patient care per diems, exclude the lower and upper 10 percent of the per diems of Step B.11. and calculate the standard deviation for the remaining 80 percent.

14. Establish the statewide cost based reimbursement ceiling for the operating cost per diem as the sum of the median plus one standard deviation and for the patient care cost per diem as the sum of the median plus 1.75 standard deviations that resulted from Steps B.12. and B.13., respectively.

15. Establish the cost based reimbursement ceilings for operating and patient care costs per diems for each class by multiplying the statewide ceilings times the ratios calculated for that class in Step B.10.

16. Effective July 1, 1996, except for only the January 1, 2000 rate semester for the patient care component, establish the target reimbursement for operating and patient care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and patient cost in Step B.16 from the previous rate semester, excluding incentives and the Medicaid Adjustment Rate (MAR), with the quantity:

$$1 + 1.4 \times \frac{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the prospective rate period} - 1}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}}$$

In the above calculation the 1.4 shall be referred to as the inflation multiplier.

For the January 1, 2000 rate semester only, the patient care component inflation multiplier in the above equation shall be adjusted upward for each provider until this adjustment in conjunction with the adjustment in B.17. c. results in an estimated additional reimbursement in the patient care component per B. 18. This adjustment in the inflation multiplier shall

not result in a patient care per diem rate that exceeds the patient care per diem costs adjusted for inflation in Step B.6 or be less than a patient care per diem cost calculated using an inflation multiplier of 1.4.

17. Establish the reimbursement ceilings for operating and patient care cost per diems for each class as the lower of:

a. The cost based class reimbursement ceiling determined in Step B.15.

b. For rate periods beginning July 1, 1996, except for only the January 1, 2000 rate semester for the patient care component, the class reimbursement ceiling as calculated in B.17.b., from the previous rate semester, inflated forward with 1.4 (inflation multiplier) times the rate of increase in the Florida Nursing Home Cost Inflation Index through a calculation similar to that given in Step B.16. No reimbursement ceiling can increase in excess of a 15 percent annual rate.

c. For the January 1, 2000 rate semester only, the 1.4 patient care component inflation multiplier shall be adjusted upward for each class ceiling until this adjustment in conjunction with the adjustment in B.16. b. results in an estimated additional reimbursement in the patient care component per B.18. The adjustment in the inflation multiplier shall not result in a patient care class ceiling that exceeds the class ceilings determined in Step B.15 or be less than the class ceiling calculated using an inflation multiplier of 1.4

18. The adjustments made to the patient care inflation multiplier in Sections I. B.1, V.B.16 and B.17. of this plan shall be made only when the January 1, 2000 rates are initially established and shall not be subject to subsequent revision. These adjustments shall result in an estimated additional reimbursement in the patient care component of $9,051,822 for the January 1, 2000 rate semester.

19. Establish the reimbursement ceilings for the operating and patient care cost per diems for the Size 1-100 bed "Central Florida Counties" and Size 101-500 beds "Central Florida Counties" classes as the arithmetic average of the reimbursement ceilings determined in Section V.B.17.

20. Compute the total cost-related per diem for a facility as the sum of:

    a. The lower of the property cost per diem obtained in Step B.7. or the applicable statewide property cost per diem ceiling calculated in B.8., for facilities not reimbursed under FRVS. For those reimbursed under FRVS, substitute the FRVS rate calculated per Section E. below, which shall be the sum of the property tax (which excludes sales tax on lease payments) and insurance per diems plus the per diem calculated based on the indexed 80 percent asset value plus the ROE or use allowance per diem calculated on the indexed 20 percent asset value.

    b. Return on equity per diem obtained in Step B.7.

    c. Incentives for both the operating and patient care costs per diems obtained in Steps C. or D. below.

d. The lower of the operating cost per diem obtained in Step B.7, the operating target per diem obtained in Step B.16., or the applicable ceiling obtained in Step B.17.

e. The lower of the patient care cost per diem obtained in Step B.7, the patient care target per diem obtained in Step B.16., or the applicable ceiling obtained in Step B.17.

f. The Medicaid Adjustment Rate (MAR) add-on as described in F below, the Case-mix Adjustment add-on as described in G below, and the Direct Care Staffing Adjustment add-on as described in H below.

21. Multiply the sum of non-Medicare or Medicaid usual and customary charges by the inflation factor calculated in Step B.6. Divide the result by the total non-Medicare or Medicaid days.

22. Establish the prospective per diem for a facility as the lower of the result of Step B.20~~19~~ or Step B.21~~20~~.

C. Quality of care and cost containment incentives for rate periods during April 1, 1983 through June 30, 1985.

1. To encourage high-quality care while containing costs, this plan provides the following:

a) Providers who receive a "conditional" licensure rating shall receive no incentive for the duration of time that the conditional licensure rating is applicable.

b) Providers that receive a "standard" licensure rating may be eligible for an incentive. For any period during which a provider has an operating cost per diem from Step B.6. below the class ceiling, an incentive of 33.33 percent of the difference between the class

ceiling and the operating cost per diem from Step B.6 shall be used in computing the provider's prospective per diem rate in Step B.19.c. This incentive shall not be greater than 20 percent of the class ceiling amount.

2. Providers with a "superior" licensure rating may be eligible for an incentive, in either the operating cost or patient care cost area or both, for the period of time during which they have a superior licensure rating. The incentives shall be determined as follows:

a) If the operating cost per diem from Step B.6 is below the class ceiling, an incentive of 66.67 percent of the difference between the class ceiling and the operating cost per diem from Step B.6 shall be used in computing the provider's reimbursement rate in Step B.19c. This incentive shall not be greater than 20 percent of the class ceiling.

b) If the patient care cost per diem from Step B.6 is below the class ceiling, an incentive of 10 percent of the difference between the class ceiling and the patient care cost per diem from Step B.6 shall be used in computing the provider's reimbursement rate in Step B. 19c. This incentive shall not be greater than 5 percent of the class ceiling.

D. Quality of care and cost containment incentives for rate periods beginning on or after July 1, 1985 through June 30, 1996.

1. To encourage high-quality care while containing costs, this plan provides for the following incentive payments. Incentives shall be paid for the current rate semester period based on a weighted average of the incentive amounts calculated using the licensure ratings that were in effect in the rate semester period 1 year prior. For operating costs, the operating cost

per diem shall be less than the class ceiling and licensure ratings other than conditional shall have been received. For patient care costs, the patient care cost per diem shall be less than the class ceiling and a superior licensure rating must have been received.

2. The calculation of the per diem incentive amounts are as follows:

(a) Determine the number of days during the 6-month period 1 year prior to the rate semester for which the facility held each of the three possible licensure ratings: superior, standard, and conditional.

Example: For the rate semester January 1, 1986 through June 30, 1986, the 6-month period 1 year prior is January 1, 1985 to June 30, 1985. During that prior period, the provider's licensure ratings were:

RATING	PERIOD	DAYS
Superior	1/1/85 - 1/31/85	31
Conditional	2/1/85 - 3/31/85	59
Standard	4/1/85 - 6/30/85	91
		181

(b) For the rate periods beginning on or after January 1, 1988, if the lower of the operating cost per diem from Step B.6 and the operating target per diem from Step B.16. is less than the class ceiling, calculate the positive difference. If the lower of the two per diems is greater than the ceiling, then skip c. through e. below.

(c) Multiply the difference in (b) above by the product of .6667 times the proportion of days in the period 1 year prior that a superior licensure rating was held. Using the example in (a) above, this product would be: (.6667) x (31/181). For rate periods beginning July 1, 1995, multiply the difference in (b) above by the product of

.64 times the proportion of days in the period 1 year prior that a superior licensure rating was held. Using the example in (a) above, this product would be : (.64) x (31/181).

(d) Multiply the difference in (b) above by the product of 1/3 times the proportion of days in the period 1 year prior that a standard licensure rating was held. Example: (.3333) x (91/181). For rate periods beginning July 1, 1995, multiply the difference in (b) above by the product of .32 times the proportion of days in the period 1 year prior that a standard licensure rating was held. Example: (.32) x (91/181).

(e) Establish the weighted operating cost incentive per diem as the lesser of: the sum of the results of (c) and (d) above; or 20 percent of the class operating cost ceiling for rate periods prior to January 1, 1988, or 15 percent of the class operating reimbursement ceiling for rate periods beginning on or after January 1, 1988, or 10 percent of the class operating reimbursement ceiling for rate periods beginning on or after July 1, 1995.

(f) For rate periods prior to January 1, 1988, if the patient care cost per diem from Step B.6 is less than the class ceiling, calculate the positive difference. If the patient care cost per diem is greater than the class ceiling, skip (g) and (h) below.

(g) Multiply the difference in (f) above by the product of (.1) times the proportion of days in the period one year prior that a superior licensure rating was held. Example: (.1) x (31/181).

(h) Establish the weighted patient care cost incentive as the lesser of: the result of (g) above; or 5 percent of the class patient care cost ceiling.

(i) Establish the total incentive payment as the sum of (e) and (h), if applicable.

(j) An example of the complete calculation is shown here, based upon the following information:

(1) Current rate semester period: January 1, 1986 to June 30, 1986;

Rate semester period 1 year prior:

January 1, 1985 to June 30, 1985;

(2) Licensure ratings in effect during January 1, 1985 to June 30, 1985:

RATING	PERIOD	DAYS
Superior	1/1/85 - 1/31/85	31
Conditional	2/1/85 - 3/31/85	59
Standard	4/1/85 - 6/30/85	91
		181

(3) The operating cost per diem is $3.00 below the class ceiling.

(4) The patient care cost per diem is $10.00 below the class ceiling.

The incentive for the current rate semester period, January 1, 1986 - June 30, 1986 is:

RATING:	**OPERATING**	
Superior	$3.00 x .6667 x 31/181=	$0.3426
Conditional	N/A x x 59/181=	N/A
Standard	$3.00 x .3333 x 91/181=	.5027

Total Operating Incentive		$0.8453
RATING:	**PATIENT CARE**	
Superior	$10.00 x .1 x 31/181=	$0.1713
Conditional	N/A x 59/181=	N/A
Standard	N/A x 91/181=	N/A
Total Patient Care Incentive		$0.1713
Total Incentive		$1.0166

This total incentive of $1.0166 is added in the rate calculation in V.B.20~~19~~.c.

(k) For rate periods beginning on or after January 1, 1988, calculate each facility's reimbursement rate for patient care costs as described in V.B. 20~~19~~.e. Multiply this per diem by .03 times the proportion of days in the rate period one year prior that a superior licensure rating was held.

Example: (.03) X 31/181). The result of this calculation will represent the quality of care incentive to which the provider is entitled. This incentive is to be included in the provider's total reimbursement rate in place of the incentive determined in V.D.2.(h).

(l) For rate periods beginning on and after July 1, 1993, incentive payments shall be prorated based upon a facility's Medicaid utilization percentage, except as modified in (m) below. Facilities with 90% or greater Medicaid utilization shall receive 100% of their incentives. Facilities with 20% or less Medicaid utilization shall receive no incentives. Facilities between 20% and 90% Medicaid utilization shall have their incentives prorated by multiplying their incentives by the percentage calculated in the following formula:

$$100 \text{ X } \frac{[\text{Medicaid Utilization \% - 20\%}]}{70\%}$$

(m) For rate periods beginning July 1, 1995, facilities with 65% or less Medicaid utilization shall receive no operating incentives. Facilities between 65% and 90% Medicaid utilization shall have their operating incentives prorated by multiplying their operating incentives by the percentage calculated in the following formula:

$$100 \text{ X } \frac{[\text{Medicaid Utilization \% - 65\%}]}{25\%}$$

E. 1. FRVS for existing facilities at October 1, 1985.

a. Each existing facility, at October 1, 1985, shall have an FRVS rate established for capitalized tangible assets based upon the assets' acquisition costs at the last dates of acquisition prior to July 18, 1984. Facilities purchased after July 18, 1984 and not enrolled in the Medicaid program prior to the purchase or facilities constructed after July 18, 1984 and enrolled in the program shall have an FRVS rate established on the basis of the last acquisition costs prior to enrolling in the Medicaid program. The acquisition costs shall be determined from the most current depreciation schedule which shall be submitted by each provider. These acquisition costs, including the cost of capital improvements and additions subsequent to acquisition, shall be indexed forward to October 1, 1985 by a portion of the rate of increase in the Florida Construction Cost Inflation (FCCI) Index based on the Dodge Construction Index. The change in the FCCI Index from September, 1984 to March, 1985 shall be used to project the FCCI

Index for October 1, 1985, with no subsequent retroactive adjustment. The costs of land, buildings, equipment, and other capital items allowable for Medicaid reimbursement per HCFA-PUB.15-1 (1993) such as construction loan interest expense capitalized, financing points paid, attorneys fees, and other amortized "soft" costs associated with financing or acquisition shall be included in determining allowable acquisition costs subject to indexing. Property taxes (which excludes sales tax on lease payments) and property insurance expenses shall not be included in the calculation of the FRVS rate, but shall be reimbursed prospectively, based on actual costs incurred and included in the total property rate. For FRVS rates calculated after October 1, 1985 but prior to July 1, 1991, the 6-month change in the FCCI Index based on the Dodge Construction Index shall be determined for adjusting FRVS rates. For rates effective on or after July 1, 1991, the FCCI Index based on the DRI/McGraw - Hill Health Care Costs, Consumer Price Index All Urban All Items South Region shall be used.

FRVS rates shall be adjusted for inflation on each January 1 and July 1, using the change in the FCCI Index for the most recent 6-month period published prior to the rate semester. FRVS rates shall be adjusted per subsections f. and j. below for changes in interest rates on capital debt instruments and for capital additions or improvements on each January 1 and July 1. (See Appendix B for computation of the index).

b. A single FCCI Index, based upon the average of the Dodge Construction indicies for the six cities in Florida for which an

index is published, shall be used through June 30, 1991 and the most recently published DRI Health Care Costs All Urban All Items South Region Index quarterly indices for July 1, 1991 and thereafter. The rate of increase in the FCCI Index, for purposes of indexing FRVS rates, shall be limited to a 3 percent semi-annual increase; however, during semesters when the increase in the index is greater than 3 percent, a credit, calculated as the actual increase minus 3 percent, shall be carried forward for future periods and added to the increase in the index, up to a maximum of 3 percent, when the actual future increases in the index are less than 3 percent. For example, if the increase in the index is 4 percent in Period 1, 3 percent shall be used and a credit of 1 percent shall be carried forward; then, if the increase in the index is 2 percent in Period 2, a 3 percent rate of indexing shall be used, by adding the 1 percent credit to the actual 2 percent increase. If more than 2 percent credits were available, a maximum of 3 percent rate of indexing would be used, and the remaining credits would again be carried forward to future periods. The credits shall carry forward indefinitely until they are reduced by applying them to periods during which the rate of increase in the FCCI Index is less than 3 percent. The credits shall accrue by individual facility, so that any facility entering the program in a period where the increase in the FCCI Index is less than 3 percent shall not benefit from credits accrued during prior periods by other facilities.

c. The portion of the FCCI Index increase used to index asset valuation each year shall vary with the number of years the facility participated in the program since January 1, 1972. For the first 10

years of participation, a straight-line increasing portion of the allowable increase in the index shall be used: 1/10 in year 1, 2/10 in year 2, 3/10 in year 3, up to 10/10 in year 10. The total percent increase allowed for any 6-month rate semester shall not exceed 3 percent. For the second 10 years, the unadjusted index increase shall be used, subject to a 3-percent semi-annual limitation. For the next 20 years, years 20 through 40, a straight-line decreasing portion of the allowable increase in the index shall be used subject to the 3-percent limit per rate semester: 95 percent in year 21, 90 percent in year 22, 85 percent in year 23, down to 0 percent in year 40. Thus, after 39 years of participation in the program, no further indexing shall be given to a facility.

d. For rate semesters beginning on or after January 1, 1986, an adjustment shall be made in indexing for failure of a licensure re-inspection and for low Medicaid utilization.

(1) Any facility which receives a conditional licensure rating and upon re inspection has not corrected deficiencies as required by the AHCA Office of Licensure and Certification, shall receive no indexing in the FRVS rate for the 6-month rate period subsequent to the re inspection.

(2) Medicaid utilization shall be calculated as Medicaid patient days divided by total patient days, for fiscal years ending in 1980 or after. The utilization will be calculated from the cost report or budget used to set the rates for the respective rate semester. For the initial FRVS rates established on October 1, 1985, cost reports received by AHCA by September 1, 1985 will be used. Years earlier than 1980

shall have no adjustment made for utilization, but rather shall receive full credit for Medicaid utilization. The adjustment for fiscal years ending in 1980 or after shall be computed as follows: if the provider's cost report or budget shows less than 25-percent average Medicaid utilization for the cost reporting period, then no indexing of asset valuation shall be given; if 25 percent to 55 percent Medicaid utilization is computed, then the portion of the FCCI Index increase calculated in subsection 1.c. above shall be multiplied by the fraction equal to the actual utilization percent divided by 55 percent; if 55 percent or greater Medicaid utilization is computed, then full indexing using the portion of the FCCI Index increase calculated in subsection 1.c. above shall be given.

e. The asset valuation of the facility shall be indexed, according to 1.a.-1.d. above, from the date of entry into the Medicaid program, but not prior to January 1, 1972, to October 1, 1985. That asset valuation, subject to the cost per bed ceiling in g. below, shall be used to initiate FRVS property reimbursement at October 1, 1985. The change in the FCCI Index from September 1984 to March 1985 shall be used to project the FCCI Index for October 1, 1985, with no subsequent retroactive adjustment. The total asset valuation shall be divided into two components: 80 percent of the total asset valuation shall be amortized over 20 years, at the interest rate specified in f. below, to determine an amount which would pay principal and interest on an installment mortgage for that 80 percent of the asset valuation. For facilities beginning

FRVS with a total initial principal balance of all current mortgages less than 60 percent of the indexed asset value, only the interest portion will be used in calculating the FRVS rate. The calculated interest plus principal or interest-only expense will be converted to a per diem by dividing by 90 percent of the maximum annual bed days of the facility. However, for newly-constructed facilities, the per diem calculated for that facility's first year of operation shall be the result of the principal and interest or interest-only expense divided by 75 percent of the maximum possible annual bed days. For those facilities that have put into service new beds for the first 12 months, the per diem shall be the result of the principal and interest or interest-only expense divided by a weighted average occupancy percentage greater than 75 percent but less than 90 percent of the maximum annual bed days if the addition of beds was 50 percent or more of the existing bed capacity, or the addition of 60 beds or more. A weighted average occupancy rate shall be computed, equal to the sum of:

1) The ratio of the new beds to total facility beds multiplied by 75 percent; and
2) The ratio of existing beds prior to the addition to total facility beds multiplied by 90 percent.

Property taxes (which excludes sales tax on lease payments) and insurance shall have a per diem calculated based upon actual historic cost and patient days as shown in the latest applicable cost report. Twenty percent of the asset valuation shall be used to calculate a return on equity for property-related equity per sections III.J. and K., and this return on equity shall be included as part of